

# HIPAA Transactions: 270/271, 278/278 and 276/277

Michigan Department of Community Health  
May 1, 2003



# Agenda

- ⊕ Welcome
- ⊕ Glossary
- ⊕ Transaction Overview
- ⊕ 270/271 Eligibility Benefit Inquiry and Response
- ⊕ 278/278 Authorization/Certification Request and Response
- ⊕ 276/277 Healthcare Claim Status Request and Response
- ⊕ Questions

# Glossary

---

# Glossary

HIPAA/Industry Term	Medicaid Term	Description
Claim	Invoice	A single paper form, or a collection of services by a single billing provider for a single patient, billed at one time.
Service Line	Claim Line	A single service generally associated with a procedure code.
Replacement	Adjustment	A billing provider's request to change a previously submitted claim.
Void/Cancel	Adjustment	A billing provider's request to void a previously submitted claim.
Health Care Claim Adjustment		The difference between the billing provider's usual charges and the paid amount. The reason for the difference is described through the use of Health Care Claim Adjustment Reason Codes.
Subscriber	Recipient/Beneficiary	The individual who is enrolled in Medicaid and receives services.
Billing/Pay-to Provider	Provider	A hospital, nursing facility, physician or dentist that submits claims to be reimbursed for care they provide to patients (subscribers).

# HIPAA EDI Terminology

HIPAA ANSI X12 Term	Medicaid Term (if applicable)	Description
Transaction		The exchange of information between two parties to carry out financial or administrative activities related to health care.
Loop		A repeating section in an EDI transaction.
Segment		A group of related data elements within an EDI transaction.
Simple Data Element		The smallest unit of information in an EDI transaction.
Composite Data Element		A more complex unit containing two or more simple data elements.
Delimiter		A character used to separate data elements in an EDI transaction.
Qualifier		A data element that describes the type of information that is to follow in an EDI segment.

# Transaction Overview

---

# HIPAA Transactions

- Transactions prior to treatment
  - **Eligibility Verification (270/271)**
  - **Authorization/Referral (278)**
- Claims and related transactions
  - Claims (837)
  - Remittances (835)
  - **Claim Status (276/277)**
- Managed care transactions
  - Enrollment (834)
  - Premium Payment (820)
  - Encounter (837)

# Prior to Treatment Transactions

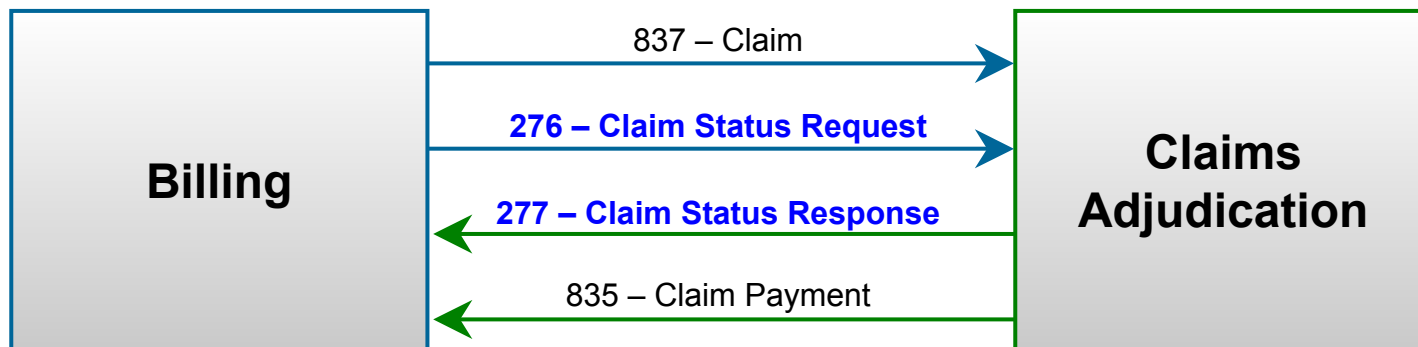




# Claim-Related Transactions

**Health Care Providers**

**MDCH**



# 270/271 Eligibility Benefit Inquiry and Response

# MDCH Eligibility Verification System

- MDCH currently contracts with outside entities to manage eligibility verification on behalf of the Department
- MDCH provides these contractors with eligibility files and updates on a 6-month, weekly or daily schedule
- Eligibility files include information for: Title XIX, Title V, MOMS, and Delta Dental Preferred and Premier beneficiaries
- Eligibility files also include: Provider file, Managed Care Provider file, Other Insurance Coverage file and MDCH Carrier file

# MDCH Eligibility Verification System

- Medicaid enrolled providers currently request eligibility verification from MDCH contractors through a variety of products, including:
  - Automated Voice Response System with Voice or Fax Back Response
  - Electronic Data Interchange (EDI)
    - PC Based Eligibility Verification System (EVS)
    - Browser Based EVS
    - Point of Service EVS

# 270/271 Overview

---

## 270/271 Overview

- ✿ The 270 is used by a provider to request eligibility, coverage, and benefit information from a payer
- ✿ The 271 is used by the payer to respond to a provider's request for eligibility, coverage, and benefit information

# MDCH 270/271 Transaction

- Goal is to implement a HIPAA 271 transaction that:
  - Supports current MDCH eligibility verification business practices
  - Provides consistency across all MDCH eligibility contractors
  
- Contractors currently receiving MDCH eligibility files and reporting eligibility and benefit information to providers:
  - Medifax
  - HDX
  - Netwerkes.com

# 270/271 Transaction Detail

---



# 270 Request Transaction Structure

ST 270

Transaction Set Header

Table 2 -- Detail

2000A — Information Source

2100A — Information Source Name

2000B — Information Receiver

2100B — Information Receiver Name

2000C — Subscriber

2100C — Subscriber Name

2110C — Subscriber Eligibility or Benefit Inquiry Information

2000D — Dependent

2100D — Dependent Name

2110D — Dependent Eligibility or Benefit Inquiry Information

SE 270



# 2000A Information Source

 MDCH

 Payer Identification Number (D00111)

# 2000B Information Receiver

## Provider

-  Provider Identification Number (Medicaid Provider ID)
-  Provider Contact Information

## 2000C Subscriber

- ⊕ Subscriber name
- ⊕ Subscriber member identification number
  - ⊕ Medicaid Recipient ID
- ⊕ Subscriber additional identification
  - ⊕ Social Security Number
- ⊕ Subscriber date of birth
- ⊕ Eligibility, service or admission dates
- ⊕ Service type code (eligibility request)

# 271 Response Transaction Structure

**ST 271**

**Transaction Set Header**

**Table 2 Detail**

**2000A — Information Source**

**2100A — Information Source Name**

**2000B — Information Receiver**

**2100B — Information Receiver Name**

**2000C — Subscriber**

**2100C — Subscriber Name**

**2110C — Subscriber Eligibility or Benefit Information**

**2115C — Subscriber Eligibility or Benefit Additional Information**

**2120C — Subscriber Benefit Related Entity Name**

**2000D — Dependent**

**2100D — Dependent Name**

**2110D — Dependent Eligibility or Benefit Information**

**2115D — Dependent Eligibility or Benefit Additional Information**

**2120D — Dependent Benefit Related Entity Name**

**SE 271**



# 2000A Information Source

 MDCH

 Payer Identification Number (D00111)

# 2000B Information Receiver

## Provider

-  Provider Identification Number (Medicaid Provider ID)
-  Contact Information

## 2000C Subscriber

- Subscriber name
- Subscriber member identification number (Medicaid Recipient ID)
- FIA worker load number
- FIA case number
- FIA county office phone number
- Patient account number (if sent in 270)
- Subscriber address, including county code and name
- Subscriber date of birth, gender



# 2000C Subscriber

(continued)

- Eligibility begin and end dates
- Specific eligibility or benefit information
  - Active, Inactive, Spend Down, Limitations, Other or Additional Payer, etc.
  - Coverage Level (Individual, Family, Dependents Only, etc.)
  - Service Type Code (General Benefits, Dental Care, Maternity, Emergency Services, etc.)
  - Insurance Type Code (Medicaid, HMO, Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Medicare Part A, Medicare Part B, Commercial, etc.)
  - Scope, Coverage, Level of Care, Program and Healthy Kids Dental District Codes
  - Long term care co-pay or deductible amounts

## 2000C Subscriber

(continued)

- ⊕ SMP eligibility authorization on file
- ⊕ CSHCS provider authorized/not authorized
- ⊕ Medicare Health Insurance Claim (HIC) number or other insurance group number (if applicable)
- ⊕ Subscriber benefit related entity name, identification number and contact information
  - Medicaid, SMP or CSHCS health plan information

## 2000D Dependent

- ⊕ Dependent name
- ⊕ Dependent member identification number
- ⊕ Other payer contract number
- ⊕ Other payer policy number
- ⊕ Specific eligibility and benefit information
- ⊕ Benefit coverage dates
- ⊕ Other payer name and telephone number

# Questions and Answers

---